

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/27/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155505		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 09/02/2011	
NAME OF PROVIDER OR SUPPLIER  ROBIN RUN HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN46268			
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F0000	<p>This visit was for a Recertification and State Licensure survey. This visit included the investigation of Complaints IN00094720 and IN0095318.</p> <p>Complaint IN00094720: Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00095318: Unsubstantiated due to lack of evidence.</p> <p>Survey dates: August 29, 30, 31, September 1, and 2, 2011</p> <p>Facility Number: 001156 Provider Number: 155505 AIM Number: 100453350</p> <p>Survey Team: Janet Stanton, R.N.--Team Coordinator Michelle Hosteter, R.N. Rita Mullen, R.N. (8/29, 30, 31, 9/1) Heather Lay, R.N. (8/29, 30, 31, 9/1)</p> <p>Census bed type: SNF--13 SNF/NF--57 Total--70</p> <p>Census payor type: Medicare--12 Medicaid--48</p>			F0000	<p>The following is the Plan of Correction for Robin Run Healthcare Center regarding the Statement of Deficiencies dated 9/2/11. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0252 SS=B	<p>Other--10 Total--70</p> <p>Sample: 15</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 9, 2011 by Bev Faulkner, RN</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Based on observation and interview, the facility failed to maintain a homelike environment in the common shower room on the Health Care unit by storing resident lifting equipment in the area. Equipment was stored in 1 of 2 common shower areas on 1 of 2 resident care units. The storing of equipment in the common shower room had the potential to affect 49 residents residing on the Health Care unit, of a facility population of 70.</p> <p>Findings include:</p> <p>During the environmental tour with the Director of Housekeeping, Maintenance Engineer #1 and Maintenance Engineer</p>			F0252	<p>The following is the Plan of Correction for Robin Run Healthcare Center regarding the Statement of Deficiencies dated 9/2/11. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and</p>		10/02/2011

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	<p>#2, on 8/30/11 at 9:30 A.M., the common shower room on the Health Care Unit was observed to have two shower stalls and an area for toileting residents. Equipment used to transfer residents was sitting in the middle of the area. There were 3 hydraulic sling lifts and 1 hydraulic stand lift being stored in the middle of the room while not in use.</p> <p>During an interview with the Director of Housekeeping, on 8/30/11 at 9:35 A.M., it was indicated the equipment should not be kept in the middle of the shower room area.</p> <p>3.1-19(f)(5)</p>			<p>will continue to make changes and improvement to satisfy that objective.I. All residents have the potential to be affected by the deficient practice. The deficient practice was corrected immediately on 9/1/11 by relocating the lifting equipment to one specific area.II. All residents residing at the facility have the potential to be affected by the deficient practice. The facility will conduct a daily round to ensure that the lifting equipment is stored in the appropriate area.III. In order to prevent the deficient practice from recurring, the facility will educate all nursing staff members on the proper storage location of the lifting equipment so that all nursing staff members are aware of the objective to provide a safe, clean, comfortable and homelike environment.IV. The facility will monitor the corrective action by performing nursing rounds daily, for one month and weekly for one month. The facility will monitor quarterly thereafter for one year. The results will be reviewed at the facility's Quality Assurance Committee and revisions will be made if needed and as directed by the committee.V. The deficient practice will be completed by 10/2/11.</p>			

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F0309 SS=D	<p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to routinely assess the bruit/thrill of an A.V. [arterio-venous] shunt hemodialysis access site for 1 of 1 dialysis residents reviewed; and failed to assess a resident for symptoms of a urinary tract infection (U.T.I.) during antibiotic treatment for 1 of 3 residents reviewed with U.T.I.'s; in a sample of 15. [Residents #9 and #23]</p> <p>Findings include:</p> <p>1. The clinical record for Resident #9 was reviewed on 9/1/11 at 9:30 A.M. Diagnoses included, but were not limited to, end stage renal disease with hemodialysis, diabetes mellitus, high blood pressure, dementia and history of urinary tract infection. A progress note from the dialysis center, dated 7/14/11, indicated the resident had an arterio-venous fistula dialysis access shunt in the left upper arm.</p> <p>The D.O.N. (Director of Nursing) indicated the assessment of a fistula bruit/thrill [the sound heard by auscultation/vibration felt on palpation]</p>			F0309	<p>The following is the Plan of Correction for Robin Run Healthcare Center regarding the Statement of Deficiencies dated 9/2/11. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.I. All residents have the potential to be affected by the deficient practice. The deficient practice was corrected on 9/1/11 to include assess for bruit and thrill of access site daily.II. All charts have been reviewed for other residents with dialysis sites and residents being treated with antibiotics. All residents with dialysis access sites will have his/her access site assessed for</p>		10/02/2011

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	<p>was usually documented on the M.A.R. (Medication Administration Record) or in the nurses' notes.</p> <p>The nurses notes and M.A.R.'s for July and August, 2011 had no documentation of the A.V. fistula bruit/thrill assessment for Resident #9.</p> <p>In an interview on 9/1/11 at 9:47 A.M., R.N. #1 indicated licensed nursing staff were supposed to check the A.V. fistula for bruit and thrill after a resident's return from dialysis.</p> <p>In an interview on 9/1/11 at 12:15 P.M., the D.O.N. indicated the facility's pharmacy used to print the fistula assessment information on the physician order rewrites, but it was not there any more. She indicated she had asked the pharmacy to put it back on the physician rewrites.</p> <p>On 9/2/11 at 9:30 A.M., the D.O.N. provided a policy titled "Dialysis Care," effective 2/1/11 and revised 4/01/11. The policy included, but was not limited to, the following:</p> <p>"... 1.(b)(ii) The access site must be checked daily with a stethoscope (bruit) and by palpating over the site with the fingertips (thrill). Document this check</p>				<p>bruit and thrill daily. All residents receiving antibiotic therapy will be observed for continued signs and/or symptoms of the infection the antibiotic is being prescribed to treat.III. In order to prevent the deficient practice from recurring, all charts have been reviewed for other residents with dialysis access sites and residents being treated with antibiotics. All residents with dialysis access sites will have his/her access site assessed for bruit and thrill daily. All residents receiving antibiotic therapy will be observed for continued signs and/or symptoms of the infection that the antibiotic is being prescribed to treat. Resident #23 was monitored for signs and symptoms of a urinary tract infection and completed course of antibiotic treatment. Resident #9's treatment administration record was updated to include daily monitoring of bruit/thrill. Licensed nursing staff have been re-educated on assessing dialysis access sites and on monitoring/documentation for those residents receiving antibiotic therapy.IV. The facility will monitor the corrective action by nurse management reviewing all orders in the morning facility meeting. Those residents with orders for antibiotic therapy and those residents with dialysis access sites will be tracked on a monitoring form and pertinent documentation will be reviewed</p>		

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	<p>on the Treatment Administration Record (TAR). If the bruit or thrill is absent, contact the attending physician...."</p> <p>2. The clinical record for Resident #23 was reviewed on 8/31/11 at 9:30 A.M. Diagnoses included, but were not limited to, dementia, diabetes mellitus, history of urinary tract infection, and bipolar disorder. The resident was hospitalized from 7/1/11 to 7/4/11 for altered mental status due to a urinary tract infection.</p> <p>A physician's progress note, dated 7/26/11 and completed by the Nurse Practitioner, indicated "Burning sensation in bladder area since this A.M." The Nurse Practitioner prescribed Pyridium for dysuria (burning during urination) three times a day for 2 days, and a U.A. [urinalysis] test was ordered.</p> <p>A "Daily Skilled Nurse's Note" entry, dated 7/28/11 at 5:00 A.M., indicated "resident requested to use the bedpan earlier this A.M. Had a large B.M. [bowel movement] in bedpan along with urine. Was unable to use urine for U.A. specimen needed due to B.M. in bedpan...." A subsequent progress note at 2:50 P.M., indicated "Resident was found in wheelchair unresponsive...." The physician was contacted and ordered vital signs to be monitored. At 4:00 P.M., the</p>				<p>by nursing management five day a week. Licensed nurses identified as failing to properly document will receive additional training and/or corrective action as appropriate. Nursing management will continue to monitor for six months and then continue as determined by the Quality Assurance Committee and will make revisions if needed and as directed by the committee. The Director of Nursing will ensure ongoing monitoring after the focused monitoring is completed. V. The deficient practice will be completed by 10/2/11.</p>		

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	<p>physician was contacted again "related to unstable vital signs...." and ordered the resident to be transferred to an acute care hospital for evaluation.</p> <p>A "Daily Skilled Nurse's Note" entry, dated 7/29/11 at 5:00 A.M., indicated "Resident returned from the hospital last night at 10:00 P.M., 7/28/11 with a new diagnosis of U.T.I. Has a new med [medication] order as well. Has not voiced any complaints and appears to be in good spirits...." A note at 8:30 P.M., indicated "Resident continues on antibiotic therapy for U.T.I. No adverse reactions [to antibiotic medication] noted at this time...."</p> <p>Nurse's notes entries from 7/30/11 to 8/4/11, indicated " no adverse reaction to antibiotic therapy," but did not address information related to signs and symptoms of a U.T.I. for which she was being treated.</p> <p>In an interview during the daily conference on 8/31/11 at 3:10 P.M., the D.O.N. indicated the nurses would document any continued symptoms, but did not document anything if the symptoms were lessening or absent.</p> <p>3.1-37(a)</p>						

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F0371 SS=F	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility failed to ensure the cleanliness of the equipment adjacent to a food preparation area. This impacted 1 of 1 main kitchens and had the potential to affect 70 of 70 residents.</p> <p>Findings include:</p> <p>During the initial tour of the main kitchen on 8/29/11 at 10:00 A.M., with the Consultant Dietitian in attendance, the following was observed:</p> <p>The backs of the convection oven, the steamer and combo oven was covered in greasy, gray fuzzy dust.</p> <p>The back area of the convection oven, steamer and combo oven was adjacent to the area where the food was cooked for the residents, on the stove and grill.</p> <p>During an interview on 8/29/11 at 10:05</p>		F0371	<p>The following is the Plan of Correction for Robin Run Healthcare Center regarding the Statement of Deficiencies dated 9/2/11. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.I. All residents have the potential to be affected by the deficient practice. The deficient practice will be corrected by re-educating the kitchen staff.II. All residents residing at the facility</p>		10/02/2011	

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F0465 SS=D	<p>A.M., the Consultant Dietitian indicated the back areas of the convection oven, steamer and combo oven needed to be cleaned.</p> <p>3.1-21(i)(2)</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the cleanliness of the floor in the bakery area of the kitchen. This impacted 1 of 1 main kitchens and</p>			F0465	<p>have the potential to be affected by the deficient practice. The facility will re-educate the kitchen staff regarding the daily routine cleaning schedule for the proper cleaning techniques of the convection oven, the steamer and the combo oven. The re-education will include the daily routine cleaning schedule of the convection oven, steamer and combo oven, already in place.III. In order to prevent the deficient practice from recurring, the facility will re-educate all kitchen staff on sanitary conditions in the kitchen.IV. The facility will monitor the corrective action daily, with monitoring to be completed by the Director of Dining Services and/or designee daily for one month and daily thereafter for three months. The results will be reviewed at the facility's Quality Assurance Committee and revisions will be made if needed and as directed by the committee. The Director of Dining Services will ensure the ongoing monitoring after the focused monitoring is complete.V. The deficient practice will be completed by 10/2/11.</p> <p>The following is the Plan of Correction for Robin Run Healthcare Center regarding the Statement of Deficiencies dated 9/2/11. This Plan of Correction is</p>		10/02/2011

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	<p>the potential to effect 70 of 70 residents.</p> <p>Findings include:</p> <p>During the initial tour of the main kitchen on 8/29/11 at 10:00 A.M., with the Consultant Dietitian in attendance, the following was observed:</p> <p>The floor of the Bakery area was found to have debris, dust and two dead bugs under the shelving unit used to store items used for baking.</p> <p>During an interview on 8/29/11 at 10:10 A.M., the Consultant Dietitian indicated the floor under the shelving in the Bakery area needed to be cleaned.</p> <p>3.1-19(f)</p>				<p>not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.I. All residents have the potential to be affected by the deficient practice. The deficient practice will be corrected by re-educating the kitchen staff.II. All residents residing at the facility have the potential to be affected by the deficient practice. The facility will re-educate the kitchen staff on routine cleaning schedule already in place, that covers the cleanliness of the floors in the bakery area and in the kitchen.III. In order to prevent the deficient practice from recurring, the facility will re-educate all kitchen staff on safe, functional, sanitary and comfortable conditions in the kitchen.IV. The facility will monitor the corrective action daily, with monitoring to be completed by the Director of Dining Services and/or</p>		

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F9999	<p>STATE FINDINGS</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>(u) The nurses' station must be equipped to receive resident calls through a communication system from the following: (3) Activity, dining, and therapy areas.</p> <p>This State Rule was not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to insure the emergency call light and the emergency intercom in the main dining room was in working order. This impacted 1 of 1 main dining rooms and the potential to effect 48 of 49 residents that ate in the main dining room</p>			F9999	<p>designee daily for one month and daily thereafter for three months. The results will be reviewed at the facility's Quality Assurance Committee and revisions will be made if needed and as directed by the committee. The Director of Dining Services will ensure the ongoing monitoring after the focused monitoring is complete.V. The deficient practice will be completed by 10/2/11.</p> <p>The following is the Plan of Correction for Robin Run Healthcare Center regarding the Statement of Deficiencies dated 9/2/11. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.I. All residents have the potential to be affected by the deficient practice. The deficient</p>		10/02/2011

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	<p>in the population of 70.</p> <p>Findings include:</p> <p>During the environmental tour on 8/30/11 at 9:55 A.M., with the Director of Housekeeping, Maintenance Engineer #1 and Maintenance Engineer #2 in attendance, the following was observed:</p> <p>When the call light in the Main Dining Room was tested, the light did not sound or light-up. The intercom located next to the emergency call light box also did not work. The communication console at the Health Care Nursing station had no area labeled for the Main Dining area call light, and there was no corresponding light lit-up for the Main Dining Room.</p> <p>During an interview on 8/30/11 at 10:00 A.M., Maintenance Engineer #2 indicated an emergency call from the Main Dining Room should signal by a light on the console at the Health Care Nursing station.</p> <p>During an interview on 8/30/11 at 10:10 A.M., Maintenance Engineer #indicated the emergency intercom in the Main Dining Room was also not working.</p> <p>3.1-19(u)(3)</p>				<p>practice was corrected on 9/1/11 by a contracted vendor repairing the dining room call light to working condition. The emergency intercom system was removed from the dining room.II. All residents residing at the facility have the potential to be affected by the deficient practice. The facility dining room emergency call light was repaired to sound and light up in the corridor and at the nurses station.III. In order to prevent the deficient practice from recurring, the Dirctor of Environmental Services and/or designee will ensure proper functioning of the dining room emergency call light.IV. The facility will monitor the corrective action with the Director of Director of Enviornmental Services and/or designee monitoring daily for one month and weekly thereafter for three months the proper functioning of the dining room emergency call light. The results will be reviewed at the facility's Quality Assurance Committee and revisions will be made if needed and as directed by the committee. The Director of Environmental Services will ensure the ongoing monitoring after the focused monitoring is complete.V. The deficient practice will be completed by 10/2/11.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155505		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/02/2011	
NAME OF PROVIDER OR SUPPLIER  ROBIN RUN HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN46268			
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